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KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Health Policy Oversight
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Update on Medicaid Pharmacy Policies Adopted by the 2010 Kansas Legislature

- Reduce Coverage of Certain Over-the-counter Medications

  Coverage for prescription drugs is optional for state Medicaid programs, but currently all states cover prescription drugs for at least some Medicaid beneficiaries. Many state Medicaid programs also cover Over-The-Counter (OTC) medications, which can be purchased at drugstores without a prescription, though Medicaid requires that the OTC medication be ordered by a physician or nurse to be paid for by Medicaid. Often, OTC medications fulfill a medical need that cannot be met by a prescription-only product. For example, Children's Tylenol (acetaminophen), a staple for treatment of fever in children, is only available as an OTC medication.

  A survey conducted by the National Pharmaceutical Council (NPC) questioned states about the coverage of eight categories of non-prescription drugs: allergy, asthma, and sinus medications; analgesics; cough and cold medicines; smoking deterrents; digestive products; H2 agonists (drugs to treat ulcers and gastrointestinal reflux); feminine products; and topical products. In 2005, thirty states reported covering at least some OTC drugs in seven or more of the categories. In an effort to limit Medicaid pharmaceutical expenditures states have placed various restrictions on OTC drugs.

  A 2010 Kansas legislative policy to eliminate coverage of certain over the counter medications for Medicaid beneficiaries is estimated to achieve savings of $71,260 SGF. Previous Kansas Medicaid policy related to OTC coverage included the coverage of some agents which ameliorated unpleasant symptoms, but would not necessarily address a critical medical need. Under the 2010 legislative policy, coverage of products not necessary to meet a medical need will not be covered by Kansas Medicaid, even if prescribed by a physician or nurse. Examples include moisturizing eyedrops and nose sprays.

  Current status: Change of coverage of over the counter medications requires submission of a State Plan Amendment (SPA). A SPA has been submitted and is under review by CMS.

- Pursue more aggressive pricing for specialty drugs

  In both private and publically funded health plans, specialty drugs are being recognized as major source of increasing cost of the pharmaceutical component of health care. In January 2010, the Government

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Accountability Office (GAO) released a report on government spending on specialty medications in Medicare, concluding that management of cost in this category is challenging. There is no standard definition of a "specialty drug," and each health plan's list is unique, but in general, a specialty drug includes any drug that is injected or infused, drugs which are very expensive (i.e. more than $5,000 for a month of therapy), or drugs used to treat diseases that require complex care (such as cancer, cystic fibrosis, hemophilia). Medicaid agencies are following the trend already seen in many private health plans, and are creating specific policies and reimbursement mechanisms for specialty drugs.

A 2010 Kansas legislative policy to pursue more aggressive pricing for specialty drugs is estimated to save $94,000 SGF. Currently, specialty drugs are not priced in a different manner than other medications covered by Kansas Medicaid, which is Average Wholesale Price (AWP), minus 13% if the medication is made by only one manufacturer, or AWP minus 27%, if the medication is produced by more than one company. Under the 2010 legislative policy, a more aggressive reduction in the price of the medication would be utilized, such as AWP minus 17% for specialty medications made by one manufacturer. The AWP list is supplied to the Kansas Medicaid fiscal agent by a subcontractor, FirstData Bank. FirstData Bank provides AWP to a majority of other state Medicaid agencies as well. Due to a lawsuit settlement, as of September 2011, FirstData Bank will stop supplying AWP to their customers. This has resulted in the need for Kansas and many other state Medicaid agencies to establish a new pricing base, since the base currently utilized will no longer be available. Potential options for the most appropriate replacement of the current AWP pricing are being analyzed by Medicaid staff. More aggressive pricing for specialty drugs is included in the analysis of other potential options for reimbursement mechanisms. Once determined, significant reprogramming of claims processing system will be required.

Current status: Once Kansas selects a replacement for the AWP a more aggressive pricing strategy for specialty drugs will be developed.

- Limit first fill of a name brand prescription to 15 days

For any patient starting a new medication, there is a possibility that the medication may not work as well as the patient or prescriber was hoping, or that the patient may experience unpleasant side effects (such as stomach upset, or itchy skin) that results in the patient wishing to try a different medication. If enough medication for a month of therapy was dispensed to the patient, inability or unwillingness to continue taking the prescribed medication can result in weeks' worth of medication being unused. Unlike many goods, once dispensed, medications cannot be returned to the pharmacy and therefore that unused medication is wasted. For costly medications, wasting several weeks' worth of medication means that Medicaid paid for hundreds of dollars of medication that goes unused.

Limiting the quantity to be filled the first time a medication is prescribed is a cost-containment tool that is not widely used, but is gaining popularity in private health plans and other state Medicaid programs, including neighboring Missouri Medicaid. A decrease in the first fill quantity allowed by Kansas Medicaid for costly medications from 31 to 15 as outlined in 2010 legislative policy is projected to save $84,000 SGF.

Current status: The policy outlining the new limitation has been written, and is currently in programming design phase.

- Expand Drug Use Reviews, provider education, and peer intervention

  Incorporation of a Drug Utilization Review (DUR) program is federally required for all state Medicaid programs. K.A.R. 39-7, 118 and 39-7, 119 outline the responsibilities and membership of the Kansas Medicaid Drug Utilization Review Board. DUR programs generally involve use of software programs that identify patients whose drug therapy is inappropriate, based on their medical history and medical practice guidelines. Inappropriate therapy may mean too much, or too little, of one or more medications. Once patients are identified, their prescribers are contacted with therapy recommendations, usually via letter and occasionally with a follow-up phone call or in-person visit. The Kansas Medicaid DUR Board selects five topics or diseases (i.e. diabetes, high blood pressure) every year; Medicaid claim information is then used to identify patients who may be on inappropriate therapy for that disease and letters are mailed. The Kansas DUR program also includes sixty in-person visits by the DUR pharmacist to prescriber's offices to help educate them on best practices and Medicaid policy.

  In addition to the federally mandated program, Kansas utilized from 2006-2009 a drug utilization review program that focused on mental health drugs. The contractor supplying this program was Comprehensive Neurosciences (CNS), and was funded by a grant from the drug manufacturer Eli Lilly. Expanded use of this program was projected in 2010 legislative policy to provide a cost-savings of $175,000 SGF. Expanded use was to include mailing letters to a larger sample of prescribers, using a larger quantity of best practice indicators, and to incorporate more aggressive direct peer-to-peer contact.

  Current status: KHPA developed a request for an expanded program based upon the advice of the Mental Health Prescription Drug Advisory Committee. However, Eli Lilly has opted to discontinue funding the CNS program. The agency is seeking other sponsors as the agency believes prescribing issues are still present and need to be addressed.

- Implement 4 brand name prescription per month limit and tiered formulary

  Many state Medicaid programs utilize monthly prescription limits, both on overall number of prescriptions and on number of brand prescriptions, as a cost-control mechanism on pharmaceutical expenditures. Some states cover as few as two brand name prescriptions and six prescriptions overall. Under current Kansas Medicaid policy, beneficiaries can receive five brand-name medications in a calendar month; for the sixth medication, policy requires the pharmacy to document the "medical necessity" of receiving more than five brand name medications. Implementation of 2010 legislative policy will change the allowed number of brand name medications without documentation of necessity from five to four. Certain classes of medications are exempted from the brand limitation; those exemptions will be reviewed at an upcoming DUR Board meeting. 2010 legislative policy exempted all mental health drugs from inclusion in the new brand limitation.

  Utilization of a tiered formulary is common among private health plans, and is also used by some state Medicaid programs. Tiered formularies designate some medications as preferred over others, and require that patients pay different co-payment or co-insurance amounts for each tier of the formulary. For states using tiered formularies, co-payments for each tier range from zero to three dollars, as allowed by federal law. Currently for Kansas Medicaid all prescriptions eligible for co-pays (several population groups are excluded by federal regulation) have a $3 co-pay. Many other state Medicaid programs also have a flat $3 co-pay.

Current status: Changing the monthly prescription limit requires change in the Medicaid State Plan. A SPA has been submitted and is under review.

- Enhanced PA system

Given continued cost increases, the healthcare system must replace inefficient manual processes with technology-based solutions wherever possible. Prior authorizations are a case-in-point.
For modern healthcare companies, a typical way of controlling costs is to focus on certain risky or high priced medicines and services ordered by healthcare providers. The most common method to manage these costs is to require authorization or pre-certification from the health plan before dispensing expensive medical procedures, drugs and/or treatment services to the plan participant. This is performed by:

- Gathering the information needed to make an authorization or precertification decision
- Applying appropriate decisioning criteria to the request
- Communicating the decision clearly and quickly to the healthcare provider and the plan participant
- Updating internal records in adjudication/claims systems and call tracking systems

The primary purpose of prior authorization (PA) is to ensure medical services and prescription drugs provided to beneficiaries are medically necessary and cost effective. PA programs manage a significant portion of Medicaid costs by requiring prescribers to obtain approval before certain medications are dispensed or medical services are provided. This is accomplished by identifying, researching and reviewing treatment plans and/or requested services or medication before the service is provided or the medication is dispensed. Additional information used to make these prior authorization determinations are the beneficiary's eligibility, the place and type of service requested, as well as the diagnosis. More specific medical details are required for some services.
The purpose of enhancing the PA process is to migrate from the mostly manual current process to a more automated process with the objective of minimizing the overall time required for all parties involved in obtaining prescriptions or medical services, and reducing administrative costs for payers and providers.
Savings anticipated from implementation of is enhanced prior authorization is estimated at $1.5 million (AF) in State Fiscal Year 2011.

Current status: An Enhanced Prior Authorization RFP was released in July, bids have been submitted and evaluated. Award of the contract is pending CMS approval. The contract was sent to CMS in October. The anticipated timeline from contract award to implementation is 4-5 months.

Update on the verification of prescription drugs to avoid abuse project

The non-medical use or abuse of prescription drugs is a serious and growing public health problem both in Kansas and across the country. According to the 2007 National Survey on Drug Use and Health, approximately 4.8% (109,000) of Kansans 12 years of age and older used a prescription pain reliever for non-medical purposes within the past 30 days. In that same year, 5.2 million Americans 12 years of age and older—2.1% of the population—used a prescription pain reliever for non-medical purposes in the past month. Since 2004, the non-medical use of prescription pain relievers has increased by 0.6% among Kansans and by 0.3% among all Americans.

Addressing the increase of prescription drug abuse is a focus nationwide. Thirty-four states have a Prescription Monitoring Program (PMP) currently active, and programs in nearly a dozen more states, including Kansas, will

be active soon. PMPs allow prescribers and pharmacists to review a patient's full medication history prior to prescribing or filling a narcotic, rather than having only the patient's history with that individual practitioner to review. Use of PMPs decreases a potential abuser's ability to get multiple prescriptions from multiple prescribers and pharmacies for personal use or sale. The Kansas PMP is poised to become active within the next few months. It is operated by the Kansas Board of Pharmacy.
Kansas Medicaid has, for many years, had limitations on a number of substances that have abuse potential. Incorporation of additional restrictions were proposed and approved by the Medicaid DUR Board in early 2010 and were endorsed by legislative policy direction in 2010. Additional restrictions include: dose optimization of long-acting narcotics, prevention of use of more than one long-acting narcotic simultaneously without prior authorization, and prevention of use of short-acting narcotics in any combination above what has been recommended by the American Pain Society as a high dose without prior authorization. For those patients for whom a higher dose of narcotics may be necessary to adequately manage their pain, the prescriber is required to have the patient sign a "pain contract."

The Patient Protection and Affordable Care act includes a provision that all prescribers must be enrolled in Medicaid. This provision's effective date is January 1, 2011. Under current Medicaid policy, the medication prescriber does not have to be enrolled Kansas Medicaid. Implementation of this provision will provide additional controls on prescribing of controlled substances.

Current status: Dose optimization of long-acting narcotics was fully implemented on 11/02/2010. Policies regarding short-acting and long-acting narcotics have been written and are in the system design phase.